WAIVER TRANSITION
QUESTION AND RESPONSES # 13
NOVEMBER 22, 2005

TOPIC	QUESTION	RESPONSE
Home and Community/Residential Supports	Can Home and Community Supports be billed on the same day as Res Supports by the same provider?	For individuals residing in licensed residential settings or unlicensed AFLs Home and Community Supports may be billed on the same day by the same provider. **However, billing of the community component of HCS is ONLY to meet the day programming needs of individuals who choose not to attend a licensed day facility. Outcomes for HCS are expected to be clearly delineated from those provided through Res Supports. This will be monitored closely through local approval and by DMA.**
Residential Supports	If someone's POC indicated and justified that the waiver recipient required 7 H/D of Res Sup level 3 how would we apply the habilitation training limit guidelines if the same person needed day programming as well? How many habilitation hours would we consider the 7 H/D of Res Support as being?	There are no established hours of training, supervision, or personal care attached to the Residential Supports definition and no specific amount of hours should be in the Plan of Care since it is based on a daily rate. Determination of limits on habilitation can be reviewed based on the number of hours required to meet day programming needs and a review of habilitation outcomes noted under Res Supports. The total Plan of Care and accompanying documentation needs to be reviewed closely in these circumstances.

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Utilization Review guidelines	Does the Division plan to re-word certain parts of the manual and the local approval checklists where the LME is asked to be accountable to "UR guidelines and processes" since we have been told that the guidelines are not “hard” limitations?	Utilization Review Guidelines are a guide and are to be used in conjunction with the person centered planning (pcp) process, however, it is also important to remember that they are a component of our waiver. The waiver submitted to CMS states that Lead Agencies must adhere to standardized, statewide UR criteria and process, in addition to the pcp process. The guidelines identify a level of support typical for individuals with the SNAP index noted in the guidelines. The Plan of Care, MR2, and SNAP must be reviewed carefully to determine if more or less services will support the individual then what the guidelines identify.
Individual/Caregiver Training and Education	Can a parent who is a paid CAP staff also receive individual caregiver training as a natural support?	No, the definition is very clear that “family” does not include individuals who are employed to care for the person. In these instances, the parent is no longer the natural support for the purpose of the definition but is a paid care provider who must meet all the requirements and qualifications of any provider.
Targeted Case Management	What are the staffing requirements for Targeted Case Management?	The following are the staffing requirements for the proposed Targeted Case Management definition currently at CMS for approval. Once approved these requirements must be adhered to: 1. A Masters in a human service degree and one year experience with the DD population 2. A Bachelor in a human service degree and two years with the DD population 3. At the time of the initial phase of direct enrollment if an individual employed at the agency at the time

		of enrollment does not have a human service degree they will have 5 years to get the degree....there is NO grandfathering of those individuals. (The five year clock starts at the time of the initial phase of direct enrollment.) This is not an ongoing process but is a one time exception. 4. If an individual does not have the experience required they will have until 7/06 to get the experience.
Billing Issues	There have been a variety of billing issues that appear not to have been addressed and many providers are not being reimbursed for service delivery. Can you address what is occurring?	We understand that there have been a number of billing issues that need to be addressed and have been working in collaboration with DMA to have these removed as appropriate.
Residential Supports	May Respite be provided on the same day as Residential Supports?	Respite and Residential Supports: Respite may be provided on the same day as Res Supports when it is provided for the purpose of relieving the AFL provider. It may not be used for individuals who reside in licensed residential settings.

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Private Duty Nursing	Does Private Duty Nursing require prior approval?	Private duty nursing: PDN is medically necessary continuous, substantial, and complex nursing services by a licensed RN or LPN. It requires prior approval by DMA Home Care Initiatives Unit...services will not be paid without the prior approval. Ensuring that the prior approval is obtained is the mutual responsibility of the cmgr, provider agency and the LME as local approver...although local approvers are not approving or denying this service, if you see PDN in the plan it is important to verify prior approval. PDN is not typical service; the individual would require substantial and complex continuous nursing care. On a related issue, it is important that nursing level of care not be billed through another service. If the provider qualifications of the service do not require an RN or LPN this should be considered. Private Duty Nursing is a regular Medicaid service and not a waiver service.
Natural Supports	Can you please clarify the term "natural support"?	Natural Supports: Planning for individuals who receive waiver funding follows the same person centered planning guidelines as any other target population within our system. These guidelines state that care should be taken to assure that purchased or funded supports do not take the place of natural supports or community resources. While purchased or funded supports are necessary, they may not contribute to the individual's development or maintenance of relationships and true community inclusion. Natural supports include family, neighbors,

		co-workers and friends. Community supports includes churches, YMCA, civic organizations, etc. These community supports encourage community participation.
Respite	In the old manual, under the respite definition it stated that the cost of 24 hours of non-institutional respite provided in a private home could not exceed the per diem rate for institutional respite. The new definition states that the cost of 24 hours of respite cannot exceed the per diem rate for the average community ICF-MR facility. My question is, what is that rate, or where can I find it?	Under the new CAP-MR/DD waiver the cost of 24 hours of respite cannot exceed the per diem rate for the average community ICF-MR facility. This rate is the rate of Institutional Respite which is $222.96/day.
Manual	When will the final version of the CAP MANUAL be available?	Edits continue to be made to the Manual. It will be posted in final format as soon as these edits are complete.
Family Members as Providers	Who/When does there need to be 3rd party authorization from the LME for family members providing services.	The local approver serves as a third party in determining appropriateness of the family member as a paid care provider. This occurs at local approval of Initial, CNR or Cost Revision.

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Plan of Care	How should health and safety issues be addressed in the Plan of Care?	Plans are often seen in which there are significant medical and behavioral challenges listed in the MR2 and, the SNAP but they are only limitedly addressed in the actual plan under the "Are there needs in my life related to health and safety, such as identified medical issues, need for behavior or crisis plan? If so, how will they be addressed?" If significant intensity of need is noted this should be a pretty robust section of the plan. Similar to the section on health and safety issues, the expectation is that the back up plan should be robust enough to truly reflect what supports are in place to address the needs of a person when regular staff is not available. In particular if the family member is the primary paid provider, what back up is available if there is an emergency other than calling 911.
Day Supports	Is there a continued expectation that Day Supports must be provided by a licensed day facility?	Day Supports is provided by licensed day facilities; therefore, the expectation is that those day programs that are serving waiver participants are expected to obtain licensure if they wish to continue to serve waiver participants. These facilities have until Aug. 31 of 2006 to hire staff, if needed, and to obtain licensure.

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Individual/Caregiver Training	What is the process for billing of conference registration under Individual/Caregiver Training and Education?	The process for billing of conference registration under Individual/Caregiver Training is as follows: -Be sure that there is enough funding for the service in the budget. When we transitioned to the new services in Sept. there was a cap placed on Ind/Caregiver training of $1500 per waiver yr. Under the definition of Family Training there was no limitation. Therefore, it is necessary to look at what has already been spent under Family Training in the plan year. -There needs to be clear outcomes in the Plan of Care that addresses what the individual or family member will gain from the conference. These outcomes and any budget revision must go through local approval. -The LME or provider agency may pay the registration up front and then bill for the training after the fact or the family may pay up front and be reimbursed once the training is complete. It is based on the LME business procedures or the provider business procedures. -Since the service is billed in 15 minute units, then you will have to calculate how many hours add up to the amount of the registration. -Documentation needs to be maintained in the client record in regard to this; i.e.

		copy of registration, etc.